PPO patients compared to other groups. Future analyses should determine whether insurance coverage is associated with access to medical care and subsequent clinical and HRQOL outcomes. These results serve as a baseline reference.

PCN143

CANCER SURVEILLANCE USING ADMINISTRATIVE DATA: HOSPITAL-BASED SERVICES FOR LUNG CANCER

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OBJECTIVES: The use of administrative datasets can be a useful tool in cancer surveillance by providing disease patterns, utilization of services, and patient characteristics. This study explores characteristics of treatment and staging among lung cancer patients in the US using hospital-based services. **METHODS:** A cross-sectional study of chemotherapy treated lung cancer patients receiving in or outpatient services from hospitals in MedAssets' health data from July 1, 2010 to June 30, 2011 were assessed for staging and treatment characteristics. The Thomas, et al. staging algorithm was applied to patient services to estimate stage of lung cancer. Descriptive statistics were calculated for the sample by stage, treatment characteristics, procedures and hospital characteristics. Patterns of care were tabulated and compared by cancer stage. **RESULTS:** The sample included 14,628 unique patients who received chemotherapy during the study period spanning over 217,000 hospital visits. The majority (75%) of hospital visits were classified as stage 1-2 compared to stage 3-4 (25%). Stage 1-2 patients experienced fewer hospital visits (5.9 vs. 12.5, $p < 0.0001$) and had a significantly higher proportion of inpatient stays (22.1% vs. 6.7%, $p < 0.0001$). Most visits (88.7%) occurred in hospital-based outpatient facilities. There were 52,289 (3.1 visits per patient) chemotherapy related visits. Primary chemotherapies included: pemetrexed disodium (16.2 %), carboplatin (34.3%) and cisplatin (11.0%). Blood transfusions and other non-surgical procedures made up the largest portion (25.4%) of all procedures performed on both groups. Finally, both groups were treated in primarily in large (>300 beds, 75.1%), urban (90.1%), and teaching (59.1%) hospitals. **CONCLUSIONS:** The cross-sectional analysis demonstrates the possible value of large-scale administrative data sets in illuminating differences in treatment characteristic in a chemotherapy-treated lung cancer population. Future analysis should evaluate the use of these data to help predict utilization and treatment patterns in larger populations.

PCN144

LINES OF SYSTEMIC THERAPY IN PATIENTS WITH METASTATIC MELANOMA IN THE UNITED STATES

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OBJECTIVES: To describe treatment patterns by lines of systemic (drug) therapy in patients with metastatic melanoma in the United States. **METHODS:** Using a large US medical claims database, patients were identified between 2005 and 2010 using ≥2 melanoma diagnoses (ICD-9-CM: 172.xx, V10.82) and ≥2 diagnoses for metastasis (ICD-9-CM: 197.xx, 198.xx). Patients were followed from the metastatic diagnosis date to death, disenrollment, or end of study period (6/30/2010), whichever occurred first. Lines of systemic therapy were identified based on the temporal order, gaps, and changes in the drug regimens. Systemic therapies and the duration of therapy in each line were examined. **RESULTS:** A total of 2546 patients with metastatic melanoma were included and 985 (38.7%) received systemic therapy. As the first documented therapy after diagnosis, 82.4% of patients received mono-therapy (38.5% temozolomide, 14.3% interleukin-2, 11.4% interferon alfa-2b, 8.2% dacarbazine, 2.9% paclitaxel, 2.5% GM-CSF) and 9.4% received carboplatin plus paclitaxel. Mean duration of mono-therapy was 60 days, ranging from 32 days on interleukin-2 to 124 days on GM-CSF. Of 287 patients (29.1% of previously treated) received subsequent therapy, 68.0% received mono-therapy (26.8% temozolomide, 11.9% interleukin-2, 10.5% dacarbazine, 8.4% paclitaxel, 3.1% interferon alfa-2b, 1.7% GM-CSF), 16.7% carboplatin plus paclitaxel, and 7.3% dacarbazine-containing therapies. Mean duration of mono-therapy was 67 days, ranging from 30 days on interleukin-2 to 238 days on GM-CSF. Among 71 patients who further received additional therapy, mono-therapy was still the dominant regimen (63.4%) with 21.1% temozolomide, 18.3% paclitaxel, 8.5% interleukin-2, 5.6% dacarbazine, 4.2% GM-CSF, and 1.4% interferon alfa-2b. Carboplatin plus paclitaxel was given to 19.7% of patients. Mean duration of mono-therapy was 63 days, ranging from 7 days on interferon alfa-2b to 90 days on temozolomide. **CONCLUSIONS:** The majority of patients with advanced melanoma didn't receive systemic therapy as captured in the claims database; among those who received systemic therapy, mono-therapy was most common.

PCN145

TREATMENT PATTERNS AND OUTCOMES AMONG PATIENTS WITH UNRESECTABLE STAGE III OR STAGE IV MELANOMA IN MEXICO

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OBJECTIVES: To identify treatment patterns of care in patients with unresectable stage III or stage IV melanoma disease in three public hospitals in Mexico. **METHODS:** Retrospective longitudinal study that includes 102 adult patients with unresectable stage III (any T, ≥N1, M0) or stage IV (any T, any N, M1) melanoma, diagnosed and treated from 2007 to 2010, at three specialty public hospitals in Mexico (Centro Médico Nacional Siglo XXI, Hospital General de Mexico and Instituto Nacional de Ciencias Médicas y Nutrición). Patient characteristics and resource utilization were reported for each stage of treatment (diagnosis, first line treatment, and second line or palliative care) and includes consultations, laboratory tests, hospitalization, surgery, hematologic support, radiotherapy and systemic treatment. **RESULTS:** The mean age at time of diagnosis was 60.44 years old CI(56.88-64.00) and a men-women ratio of 1.17:1, 86% in clinical stage III and 14% stage IV. The total cost of diagnosis was $15,628.10 CI($9,329.07-$21,927.14), which includes: consultations $4,225.96 CI($3,423.20-$5,028.72), laboratory tests $5,930.40 CI($3,768.31-$8,092.49), and hospitalizations $5,471.74 CI($1,188.12-$9,755.37). During first line treatment, 44.9% of all cases report hospitalization, 21.8% radiotherapy, 69.2% surgery and 76.9% systemic therapy (Dacarbazine 28.8%, Interferon-α 66.1% and Temozolomide 5.1%), with a total cost of $76,162.57 ($64,771.54-$87,553.59). Only 37.2% report a second line treatment, with a mean cost of $25,816.83 CI($21,638.70-$29,994.97), the systemic treatment (monotherapy or combined) included CDDP 11.5%, Dacarbazine 61.5%, Interferon-α 19.2%, Paclitaxel 11.5%, Carboplatin 3.8% and Vinorelbine 3.8. **CONCLUSIONS:** In this study, 76.9% of the patients received first line systemic treatment, and only 37.2% received a second line active treatment or palliative care. The lack of active treatment could be associated with a poor performance status in these patients, as well as a lack of availability of effective drugs for the treatment of unresectable stage III or stage IV melanoma in the public Mexican hospitals.

PCN146

SPECIALTY CARE AND TREATMENT IN MEDICARE HCC PATIENTS

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OBJECTIVES: To explore physician specialty patterns for the treatment of hepatocellular carcinoma (HCC). **METHODS:** Medicare patients diagnosed with HCC in 2000-07 with >=1 claim for HCC-related physician visits post-diagnosis were studied through 2009 using SEER-Medicare data. Transplant patients were excluded. Visits by specialists seen within 4 weeks of diagnosis and by therapy within the first treatment week were explored. Specialties: Gastroenterology (GE), General/Family/Geriatric/Internal (GF), Diagnostic/Intervention radiology (DIR), Hematology/Medical oncology (HMO), General surgery/Surgery oncology (GSO), Radiation oncology (RO), Multispecialty clinic/group practice (MG), Others. Therapies (non-mutually exclusive): surgical resection, percutaneous ablation, transarterial chemoembolization (TACE), bland embolization, systemic chemotherapy, selective internal radiation therapy, external beam radiation therapy. We examined second-line therapy, specialists seen since week 5, and multiple-specialty visits as related to multiple-first-line therapies. **RESULTS:** Of 6472 patients with>=1 specialist, 25% saw GE, 10.5%GF, 23% DIR, 28%HMO, 16% GSO, 4% RO, 5.5%MG, and 66%Other; 52% saw >1 specialist type within 4 weeks of diagnosis, 5%none until after 4 weeks; 6% had a resection as first line, 8%ablation, 9%TACE, 0.7%TAE, 9%chemo, 1%SIRT, 8%EBRT; 64% were untreated; 46% of patients saw only 1 specialist type in the first 4 weeks and 4% got >1 therapy form in the first treatment week. The specialties distributions did not differ across first-line therapies. Other specialists were seen by 65% of patients. GE and HMO were the most common specialty: 21-29% of patients saw GE and 23-37% saw HMO, 20-24%DIR, 11-17%GSO, 9-13%GF, 4-6%RO, and 1%MG, across therapies. Of the 2819 patients who saw only 1 type of specialist in the first 4 weeks, 52% visited Others, 13%GE, 11%HMO, 10%DIR, 6%GSO, 5%GF, 4%RO, and 0.4%MG. **CONCLUSIONS:** HCC patients commonly see Gastroenterologists and Hematologists/Medical oncologists within 4 weeks of HCC diagnosis. There was no clear HCC treatment pattern by specialist type.

CANCER – Research on Methods

PCN147

EVALUATING CONTEMPORARY PRACTICE IN CML VIA A RETROSPECTIVE RESEARCH REGISTRY OF PATIENTS ACROSS A COMPREHENSIVE CANCER CENTER DATABASE

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OBJECTIVES: Observational data of chronic myelogenous leukemia (CML) patients is difficult to obtain outside of a randomized clinical trial (RCT) setting. A retrospective research registry was developed to evaluate the outcomes of CML treatment decisions. **METHODS:** The CML cohort was created through a master patient index (MPI) across the Huntsman Cancer Institute, University Hospital, and Outpatient Clinics. Patient records (1995 – 2010) were included with CML ICD-9 codes (250.1, 205.10-12); age ≥ 18; a listing in the Utah Population Database; and chart review, including physician notes and laboratory results, indicative of CML. **RESULTS:** A total of 234 patients had confirmed CML (140 males, 59.8%). Mean age at diagnosis was 46 (SD= 15.1). Of those, 211 subjects (90.2%) were diagnosed in chronic phase (CP), 12 (5.1%) in accelerated phase and 5 (2.1%) in blast phase (BP) with 15.5 (median; 14.6 mean, SD= 4.2) CML cases diagnosed per year. Baseline lab results and comorbidity scores were not statistically significantly different by stage, except for an elevated platelet count in BP ($p=0.01$). First line treatment was a tyrosine kinase inhibitor for 51.3% overall, and 77.1% in new cases from 2001. Bone marrow transplant was utilized in 16.7% of patients overall. After 10 years, overall survival for the CML cohort was 59.5%. Overall survival was 84.8% for patients diagnosed in CP and treated with imatinib, 63.1% for patient's receiving BMT and 41.4% for patients treated with interferon-alpha. The most common cause of death overall was CML (45.1%); in those receiving imatinib 38.9% died from CML. **CONCLUSIONS:** Clinical outcomes data integrated via a MPI across a comprehensive research database to